Form Information

CIGNA Medicare Services®

Prescription Drug Claim Form

REASON FOR REIMBURSEMENT

This claim form can be used to request reimbursement of covered expenses.
Please check which reason applies *(at least one must be checked)*:

- ☐ Emergency
- ☐ Non-Participating Pharmacy
- ☐ Primary coverage is with another insurance carrier. Please provide explanation of benefits (EOB) or denial letter from the primary insurance carrier.
- ☐ Eligibility *(Please explain)* _____
- ☐ Other *(Please explain)* _____

BENEFICIARY INFORMATION

ID NUMBER *(on the front of your prescription drug ID card)*: _____

RxPCN *(on the front of your prescription drug ID card)*: _____

BENEFICIARY NAME: _____

BENEFICIARY BIRTHDATE:
Month: _____ Day: _____ Year: _____

BENEFICIARY SEX:
☐ Male ☐ Female

I represent that the beneficiary information entered on this form is correct, that the beneficiary named is eligible for the benefits and that the beneficiary has received the medication described. I also represent that the medication received is not for treatment of an on-the-job injury. I also authorize release of all information pertaining to this claim to the plan administrator or its designees.

Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act which is a crime.

BENEFICIARY SIGNATURE: _____ DATE: _____

DAYTIME PHONE NUMBER: _____

PRESCRIPTION INFORMATION

1)

Date Filled	RX Number	Qty.	Day Supply
_____	_____	_____	_____

Drug Name & Strength	NDC	Amt. Paid
_____	_ _ _ _ _ _ _ _ _ _ _	$ _____

Pharmacy Name	Pharmacy NABP
_____	_ _ _ _ _ _ _

Pharmacy Address _____

2)

Date Filled	RX Number	Qty.	Day Supply
_____	_____	_____	_____

Drug Name & Strength	NDC	Amt. Paid
_____	_ _ _ _ _ _ _ _ _ _ _	$ _____

Pharmacy Name	Pharmacy NABP
_____	_ _ _ _ _ _ _

Pharmacy Address _____

INSTRUCTIONS

BENEFICIARY INFORMATION

1. Complete ALL information on the front side. Claims missing information may be denied, delayed or returned.

2. Sign and date the Certification Statement in the area provided.

3. Complete the RETURN ADDRESS section below.

4. Submit a separate form for each family member.

5. The Prescription Information section must be completed for each prescription for which you are seeking reimbursement. If you need help completing this form, contact your pharmacist.

6. **Keep a copy for your records.**

7. Mail the claim form within 90 days of the prescription fill date, along with original receipts (cash register receipts are not acceptable), to: Connecticut General Life Insurance Company
   Pharmacy Service Center
   P.O. Box 5950
   Scranton, PA 18505-5950

8. Questions? Please call the Customer Service number located on your ID card.

Fold

Fold

RETURN ADDRESS

IMPORTANT: PLEASE PRINT. THIS WILL APPEAR IN A WINDOW ENVELOPE FOR RETURNS. PLEASE PROVIDE CURRENT ADDRESS INFORMATION BELOW:

_____ **BENEFICIARY NAME**

_____ **BENEFICIARY STREET ADDRESS**

_____ **BENEFICIARY CITY, STATE, ZIP**

Click Here to Print Clear Fields